U.S. Department of Labor

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Issue date: 11Apr2001

Case No.: 1999-LHC-1058
OWCP No.: 6-167111

In the Matter of:
RONALD RILEY,
Claimant

V.

INDIANA-KENTUCKY ELECTRIC,
Employer
and
WAUSAU INSURANCE GROUP,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances:
Ed. W. Tranter, Esq.
Ft. Thomas, KY
For the Claimant

Julie A. Gregory, Esq.
Louisville, KY
For the Employer & Carrier

Before: **THOMAS F. PHALEN, JR.**
Administrative Law Judge

AMENDED DECISION AND ORDER - AWARDING BENEFITS

This is a claim for workers' compensation benefits under the Longshore and Harbor Workers' Compensation Act as amended (33 U.S.C. §901, et seq.), herein referred to as the "Act." The hearing was held on November 23, 1999, in Cincinnati, Ohio, at which time all parties were given the opportunity to present evidence and oral arguments. Post-hearing briefs were requested herein, and timely filed. The record was held open for receipt of the vocational evaluation report of J. Thomas Davis, Psg.D, Licensed Clinical Psychologist, which was timely received into evidence as Claimant's Exhibit G, pursuant to my hearing order. The following references will be used: "T" for the official hearing transcript; "JX" for a Joint Exhibit, , "ALJ EX" for an exhibit offered by this Administrative Law Judge, "CX" for a Claimant's exhibit, "DX" for a Director's exhibit and "EX/RX" for an Employer's exhibit. Full consideration has been given to the entire record in this matter.

Stipulations and Issues

The parties stipulate, and I find**:**

1. The Act applies to this proceeding.

2. Claimant and Employer were in an employer-employee relationship at the time of the accident/injury.

3. The accident/injury occurred in the course and scope of Claimant's employment.

4. On August 10, 1995, Claimant suffered an accident/injury.

5. The Employer was advised of or learned of the accident/injury on August 10, 1995.

6. Timely notice of injury was given the Employer.

7. Employer filed a first Report of Injury (Form LS 202) with the Secretary of Labor on August 16, 1995.

8. Claimant filed a Claim for Compensation (Form LS-203) on May 21, 1996.

9. Claimant filed a timely notice of claim for compensation.

10. The Employer filed timely notices of controversion (Form LS-207) on January 29, 1996, and June 3, 1996.

11. The parties attended an informal conference on June 10, 1998.

12. Disability payments have been made as follows: Temporary Total from 8/11/95 to present at $505.59 per week; total $146,621.10, as of April 13, 2001, which is continuing.

13. Reasonable and necessary medical benefits have been paid by the Employer to date in the amount of $32,143.00.

14. Claimant's "usual employment" consisting of his/her regular duties at the time of the injury as determined under Section 8(h) of the Act are as follows: Coal equipment operator "B," and has not returned to work for the Employer.

15. (Skip)

16. (Skip)

17. The applicable average weekly wage at the time of the accident/injury was $758.38, and his hourly rate was $16.30.

18. For a one-year period immediately prior to the accident/injury, the Claimant was a five-day-per week worker.

19. The date of maximum medical improvement is to be defined by the medical evidence.

20. Claimant has demonstrated a causal relationship between his/her alleged disability and his/her work accident. Therefore, he/she has invoked the presumption of causation contained in Section 20(a) of the Act.

(Derived from JT EX 1, TR 12-14)

The unresolved issue in this proceeding is:

The extent and duration of permanent disability, under 33 U.S.C 908.

The Employer has a right to have Claimant submit in person to a vocational evaluation. (T 14)

The following exhibits were received into evidence: Administrative Law Judge Exhibits 1 - 4; Joint Exhibit 1; Claimant's Exhibits A - F; and Respondent/Employer's Exhibits 1 - 9. (T 7 - 10) The post-hearing submissions of Claimant's Exhibit G and Respondent/Employer's Exhibit 10, are also received into evidence.

For the reasons stated herein, the Court finds that the Employer had timely notice of the Claimant's injury, and that the Claimant filed timely claims for compensation. This court further finds that the Claimant suffers from chronic pain from a closed head injury, vertigo, seizures, post traumatic headaches, memory

loss, organic personality and depressive disorders, suffered during the course of his employment, or as a result thereof, and that the Employer is responsible for the benefits awarded herein.

On the basis of the totality of this record and having observed the demeanor and having heard the testimony of a credible Claimant/witnesses, I make the following:

Findings of Fact

Hearing Testimony:

The Claimant, Ronald D. Riley, ("Claimant" or "Mr. Riley," herein) was born on February 7, 1944. (T 17) He is now age 56. He is not presently employed, having been unable to work since a head injury on August 10, 1995. This resulted in the above effects, with a maximum medical improvement date of June 6, 1996. (T 15)

At the time of his injury, Claimant was working on the river, on the barges as a "CEO coal handler," operating heavy equipment, changing barges. This included earth movers, (pay loaders that they lower onto the barges,) and back hoes. He operates all of them to move coal, using his arms, hands and legs to operate levers on the equipment. (T 17 - 18)

The Claimant started working at Kentucky Electric on September 18, 1972, ("Respondent," "Employer," or "EBC," herein) with about 24 years there before he got hurt. He first worked as a utility person, thereafter bidding into other classifications, such as two years as a barge attendant, changing barges with a harbor boat to put them under the stations, characterizing his work as "extremely physical." (T 19-20) I take administrative notice that the Employer is a maritime facility adjacent to the navigable waters of the Ohio River, where it unloads coal for its own commercial use as a public utility.

Mr. Riley finished high school, with no other special training (TR 20) except on the job training for the heavy equipment that he utilized. He has been married to Mildred Riley since 1992. (p.8, infra)

On August 10, 1995, they were moving an empty barge with barge pullers, utilizing heavy cables. They then pushed a full barge underneath the station to offload coal. One 7/8 inch cable was "hung up" on the end of the full barge, which was extremely high. Just as he looked around the corner of the barge to see why it was hung up, the cable sprang loose, like a bow spring on a bow and arrow, and hit him along the side of the head, just above his right ear and temple. It sent him 12 to 14 feet into the air, and he landed on the end of the barge. (T 21-22; CX E)

Although he was dazed, and was somewhat in shock, Claimant was taken from the barge to King's Daughter's Hospital in Madison, Indiana, for treatment. His wife had to stay awake and sit with him all night to make sure that he was not suffering from effects of the head blow, such as a concussion. (T 24) The next day, he went to the company doctor, Dr. Graves at Madison Clinic, who referred him to a neurologist, Dr. Duane Birky, who diagnosed a contusion. (T 25-27)

Dr. Birky saw him for a period of time, prescribing various medicines but no surgery, and later turned him over to Dr. Winikates from the same office, who replaced him when he moved from the area, and has continued his treatment until the present day. (T 28-29)

As a result of the accident, Claimant has had bad headaches, shingles, and back and leg problems. (T 30) Aside from medications, he has not had any other treatments for his back injuries but his head injury resulted in trouble walking, balancing, vertigo, and standing. At times, he would just fall down; one time, having fallen out of a chair right to his face. (T 31) He now feels that they are getting worse. (T 32) Exhibit E, referred to above, is a photograph showing the effects of face shingles, from which he has had a lot of scarring on his face. (T 33) The shingles occurred almost immediately and the picture was taken 8-10 days after the accident on August 10, 1995. (T 33) While the actual injury took place to the right side of his head, above his temple, the problems with his head have occurred on his left side. (Attorney Tranter noted that the two are related in the medical testimony, there is a description of how the impact to the right side results in damage to the left side of the brain. T-34) Mr. Riley testified that as a result of the accident he could not do "virtually everything" that he could do; (T 35) meaning that he cannot drive, he cannot get out and walk, or take care of himself at home. (T 35) He called himself a "workaholic" before his injury, and would work sometimes as much as 16 hours a day for 6 days a week, working at one time, 3 ½ months, 12 hours a day, 7 days a week. (T 35)

In addition, he loves to fish and hunt which he cannot now do, and has not operated a motor vehicle since the accident. (T 36)

In addition, he has had memory loss forgetting people that he had talked to on the phone. (T 36) He used to be able to figure his checkbook in his mind and write it down and he is now unable to do it, having a hard time balancing it, and his wife has to check that. (T 37) Everything is affected by his lower back and leg problems, and he sometimes falls when he is walking. (T 37) In fact, he walks on the grass for about 50 feet when he walks the dog so that if he falls, he would fall on the grass. (T 38) In order to shower, he has to wait until his wife is home and places a stool in the shower. (T 39) His wife gets in with him to take the shower. (T 39) During the day, he listens to the stereo and watches television. (T 39) He does not go anywhere by himself outside of the home. (T 40)

The only injuries he has had since August 10, have been the result of falling as described above. For instance, he fell a couple of weeks ago and hit the computer cabinet and had to go to the hospital, where they gave him a shot for pain. This was a result of dizziness. (T 40-41)

In terms of other illnesses, in 1994 he had a heart catheterization of one vein, but nothing since the accident in 1995. (T 41) Right now he just received his medication for his heart. (T 41) He takes Ecotrin, Norvasc, Muiracide, Xanax, Paxil, and K-dur prescribed by Dr. Estes, a cardiologist; and Ultram, Cyclobenzaprine, and Depakote, prescribed by Dr. Winikates. (T 42) (See Dr. Winikates deposition.) Other than the medications, Dr. Winikates has informed Mr. Riley that he should try to get a wheelchair because he can't go very far walking. (T 43)

In terms of his communication with others, he forgets what he is saying or he will tell them over again the same thing he told them previously without realizing it. (T 43) He believes that he could not sell items over a counter, make change or actually sell merchandise. (T 43-44) When he purchases things, most of that is done by his wife. (T 44)

On cross examination, he testified that since his injury he did not look for any type of work over the three or four years; and that he has not done any odd jobs on the side such as helping a friend or doing minor construction work or odd jobs. (T 44)

In the summertime, he sometimes sits outside on a bench outside the door and does not go places away from home, like the grocery store or church. (T 45) His wife has just opened up a restaurant and is gone during the day. (T 40) Various members of the family check on him when she is gone. (T 40) The name of her restaurant is "Millie's Diner" in Prestonsville, Kentucky, right across the bridge in Carrollton. (T 45) Occasionally, he goes with her to the restaurant while she is taking care of business and would sit in a corner table just to get out. (T 46)

Mr. Riley's wife had tried to arrange for a trip and made a $400.00 deposit on his credit card.

From his testimony it appears that he was not able to go and has not traveled in the last three or four years. (T 47)

Mr. Riley did not recall having angioplasty by Dr. Estes in January, 1996, a few months after his accident in 1995. (T 48-49) According to his office notes, the diagnostic catheterization was November 15, 1994 (Tab 4, page 78-79 - King's Daughter's hospital records) and the operative note itself shows status of angioplasty on page 40. (T 50-51)[1]

It appears that he has now also seen a rheumatologist Dr. Eshan Moshen in Jeffersonville, Indiana for arthritis, lupus and gout. (T 53) The condition resulted in stiffening of the joints, problems trying to walk and lower back problems, which he testified he never had until after he got hurt. (T 54) Dr. Moshen had him on Plaquenil, Celebrex and Hydrocroxicor, and in addition, quinine. He sees him every three months, checks his blood, issues prescriptions, and has referred him to an eye doctor because of the medications. (T 54-55) The eye doctor, Dr. Robert D. Williams, M.D., of Dr. Tolstein Eye Center, is a surgeon and glaucoma specialist, who has not determined any problem but needs to be treated. (T 55-56)

Confirming that he has stiffness in the lower back and joints from the arthritis and lupus, they give him problems walking. He would not confirm that both conditions caused him to loose his balance, but did state that he does have problems losing his balance. (T 56) Before the accident, he had a tremendous amount of fluid and swelling around his feet (T 56), but in July of 1996, he was diagnosed with zero negative arthritis (T 57) almost a year after the injury.

Mr. Riley confirmed that he received the following benefits: $505.00 from State Workers' Compensation (although these benefits were not paid by Employer); $736.00 from Social Security Disability; and $509.00 from his early retirement from his former employer. He sees Dr. Estes every two

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[1]Part of the Employer's defense is that some of Mr. Riley's problems would pertain to his heart condition as opposed to the work injury; that he has had continued heart problems after the work injury and that the heart surgery, the second procedure, the most invasive procedure, was done in January of '96." (T 50-52) Medical records from Dr. Estes show that at the time of the accident Mr. Riley was already taking the Norvasc, aspirin, Xanax, Lodine, Nitrostat and Paxil (T 52) which he took both before and after the injury. (T 53)

months for his heart but has not had any incidents in the past three years, stating that his heart was doing so good that he might take him off his medicine. (T 58-60)

I generally credit the testimony of Mr. Riley but recognize that he has certain memory problems and inconsistencies as a result of his conditions. I do not attribute this to any attempt to be untruthful in his testimony. However, the medical records will have to be the primary consideration in weighing the effects of his injury or his conditions.

Mrs. Mildred Riley, Ronald's wife, testified that early in 1996 he had a small blockage that they wanted to clear up, and, as a result, Mr. Riley had an angioplasty. With regard to August 10, 1995 accident, Mrs. Riley testified that before it he took care of all the finances and she did not have to take care of anything; that he did household work and can't do anything now, and that he can't even balance a checkbook or take a shower by himself anymore. (T 63) She stated in one instance the bank sent a check back because all that it had on it was scribbling and was confused. Thinking that he had signed the check, he made it out and sent it out, but he didn't even sign it, he just scribbled on it. (T 63) As a result, she "had to put the checkbook up", and not let him write checks. (T 63) Even though he had previously done all the finances, she now has to write all the checks and pay all the bills, taking care of all the finances (T 64). He cannot do any of the household chores including cooking. In one instance, "he got burnt" trying to fix an egg, turning the skillet over on him. He can't even work the microwave. (T 64) She says he would just stand there and look at the microwave and not know how to use it.

If Mr. Riley tries to take out the garbage or sweep, he falls. Once, going to the refrigerator he fell straight back and she got hurt trying to break his fall because there is no warning. She testified that you never know when he is going to fall. (T 65)

Mrs. Riley stated that before the incident he was very intelligent, physical and very smart. His English vocabulary was perfect and now he can't even make a sentence. (T 65) She said that he was athletic, they would go to the movies, they would take walks and play tennis, and now he can't even play tennis. (T 66) He cannot drive. He tried to at one time, ran off the road and on to somebody's porch, six months after the accident. He ran out of the house, got in his truck, drove off and before she could stop him, he had wrecked it. (T 66) She stated that when he talks, all of a sudden he starts slurring his words, and you don't know what he is saying. Then he gets frustrated and he thinks he is saying it right and he is not but they cannot understand him. (T 67) It is no longer at just certain times, where that would happen when he was tired and it would get worse. Now, she stated, it was "all the time." (T 67) He even gets confused on who she is. She stated that one morning he got up and looked at her and stated "I'm getting ready for school, Mom, just don't holler at me." She told him there was no school and to go back to bed, and then he was all right. (T 67) She just goes along with him, and he goes back to sleep, but if she argues with him, he gets upset. (T 67)

Mrs. Riley testified that one time the apartment caught fire, the alarm was going off, and she "stopped by to check on him." She had to awaken him, the apartment was full of smoke. The air conditioner unit had caught on fire and it just kept running because no one was shutting it off. He didn't know how to shut it off. (T 68) She then listed a number of other things that had happened as a result of him not remembering. (T 69-70)

He was so upset about needing her help in the shower, she had to have a handicapped bar installed. One night, he had a seizure and almost drowned on her before she could get the water out of the bathtub to get him out. She stated that the doctor said he could not get into the bathtub anymore. So she got a stool for him to have a shower. He cannot take one himself. (T 70)

She also testified that he had duplicated his medicine (Dilantin), so she had to put the rest up so he couldn't get at it. (T 71) He takes the Dilantin which she corrected to be Dayprocote for seizures. (T 71) She says he falls as many as four or five times a day. (T 71) She testified that he even forgets to do things he's doing such as going to the bathroom. (T 71-72) He doesn't remember what he is watching on TV. One time he invited sales people in to see him, and a neighbor had to ask them to leave. She testified that's when she knew she had to have somebody stay with him. (T 72)

He does sit in the restaurant with her but falls. One time, the Pepsi driver had to help her get him of the floor. (T 73) Another time, he fell when he was trying to do dishes, and broke about six of them, so she stopped having him do that. (T 73)

She said on one occasion since August 10, 1995, he fell down the steps, scraped his arm and hit his head again. (T 73) When asked whether he had increased symptoms as far as a head injury after the accident, she stated "he just gets more confused." (T 73) He fell in the restaurant, and she had to keep him awake for 24 hours with a concussion. (T 74) (This happened on October 28, 1999 - T 74) Overall, his symptoms have gotten "a lot worse. It's sort of a gradual thing." (T 74)

On cross-examination, Mrs. Riley testified that they had been married for seven years, since 1992. (T 75) The only heart problem that she knew of was the one that had been described above, resulting in a catherization in 1994, after which he saw Dr. Estes through 1995, and he says that he is doing fine. (T 75-76) She also verified the arthritic treatment with Dr. Moshen.

With regard to an instance where he fell and hit the computer table, she testified that this was not at work, it was at home, and that Mr. Riley does not use the computer, he does try to play with it, but cannot do anything and gets frustrated. (T 77) She also verified that the trip they had planned for a vacation by plane had to be cancelled. The trip was planned for Las Vegas in October of 1999, and they did not go. (T 78) They have not had any vacation since the accident, or anything planned over the holidays or for the next six months. (T 78)

She stated that he is unable to stay by himself anymore, and Dr. Winikates said that he could be in the early stages of Alzheimer's because of the accident. (T 78)

I credit Mrs. Riley's uncontradicted testimony in full, as a witness who is living with Claimant on a day-to-day basis, and attempting to give an objective account. Although her emotional involvement does lead to some exaggeration, I credit her anecdotal accounts of incidents that have occurred generally, but must rely on the professional reports in the final analysis of his conditions.

Mr. Charles D. Holloway testified as Mr. Riley's half-brother. (T 80-81) He testified that he takes care of Mr. Riley when his wife is not at home, to be certain that he doesn't fall when he goes to the

bathroom, etc. Since his accident, he goes to sleep and sometimes he cannot wake him up, which is different than he was before the accident. (T 82) He stated that "he could converse on just about any[thing] and use words that you could understand" but now he gets to talking and forgets what he was saying. He can't grasp the words to remember what he is trying to say. (T 82) Mr. Holloway testified that he does not work and he is on disability due to a fall at work in 1985, and had a bad back. (T 83) He had worked at Webster's Drug delivering medicine, and stocking the stockroom. He received a lump sum settlement of $15,000.00 on the Workers' Compensation and then he started drawing Social Security disability. He was 60 years old and would be 61 on November 30th. (The hearing being on November 23.) (T 84) He does not receive money from Mr. and Mrs. Riley for staying with him, and does for two or three days a week. He calls at least two or three times a day and goes over and sees Mr. Riley at least once or twice. (T 85)

I credit Mr. Holloway's uncontradicted testimony.

The second half-brother, Walter C. Holloway, also testified that he would go to Ron's house to watch over him while his wife was at work, from time to time. Charles is the primary person that helps out and he does so at other times. (T 88) With regard to his behavior after the accident, he testified "I used to have a brother. I don't have one now, that we can go out and have fun together and maybe do a little fishing and bowling." (T 88) He now can do none of those activities. (T 88) If telling a story, he will repeat the same story forgetting that he told it, stating that before the accident he was "sharp as a tack." (T 89) Mr. Walter Holloway is a production coordinator at Atochem Chemical Factory in Carrollton, Kentucky. He is on three days and off three days, working from 6:00 a.m. until 4:00 in the afternoon, and would watch his brother for approximately once or twice a week over the past year. (T 91) Sometimes he would just drop in to check on him, and stay for a couple of hours. (T 91) He does not take him anywhere with him. (T 91)

I credit the uncontradicted testimony of Mr. Walter Holloway.

Medical Evidence

Dr. Duane Birky:

Dr. Birky addressed a letter of August 14, 1995, to Dr. Graves of the Madison Clinic, recounting Mr. Riley's accident of August 10, 1995, who, at age 53, was struck by a 3/4 inch steel cable on the right side of his head. While Mr. Riley recounted that he does not believe he was unconscious, there was a period of time where he was unable to remember events, and Dr. Birky characterized that time period as "transitioned alteration unconsciousness." (CX B) The skull x-ray revealed no abnormality but the neck x-ray did suggest "some degenerative changes in posterior spurring and perhaps even mild encroachment of the C-5/6 intervertebral foraman bilaterally." His main complaints were headaches and neck pain, with the headache being "more or less non-stop," and at times "a sharp stabbing sensation as if a ice pick was stabbing through his left temple region." He has difficulty focusing at times, "unlevelness" in "his vision." His wife noted unequal pupils since the time of his accident, but never before; trouble concentrating and sleeping, and apparently changed personality. Dr. Birky noted a history of coronary artery disease and a

mild heart attack in November, 1994; that he was a heavy smoker, now smoking about one pack per day. (CX B, p.p. 33-35)

He noted experience of mild pain with restricted range of motion to his head (30% of lateral and interior fluxion). He had significant pain decapitation over the cervical paraspinal muscles in trapezius muscles. The cranial nerve exam revealed a mild aniscoria, with the right pupil one half mm larger than left, both reacting to light. His gait was very slow and methodical and he was careful to avoid movement to his neck. Dr. Birky's impression was: 1) post-concussion syndrome, and 2) cervical strain, stating that "injury definately did cause a cervical strain." He recommended that he be off for two weeks for physical therapy to alleviate the muscle pain and spasms in his neck. He prescribed Nortriptyline and Flexeril, plus Floricet for headaches. He did not recommend further studies at that time.

On August 28, Dr. Birky submitted a second report noting improvement in the shoulder but significant headaches with burning sensation in the left side of his face particularly around the ear. His jaw "pops all the time" and he has trouble with excessive drowsiness. The previous week his wife found him having an apparent chronic seizure and another at the bottom of the bed. He had obvious "asymmetry in his face, neck and shoulder." His right shoulder was much lower than the left, and when he opened his mouth, there was a "palpable clicking made on each side." He had "exquisite tenderness over the left mastoid region and down the left side of his neck." Dr. Birky's impression was: 1) post-concussion syndrome, 2) cervical strain, 3) rule out TMJ syndrome, and 4) possible seizure, but noting that an EMG from the previous Friday had not yielded a result. He ordered an MRI of his neck, and noted the left-sided head and neck symptoms could be radicular in nature, and suggested an MRI of his brain. He changed medication from Floricet and Flexeril to Norflex and Mono-Gesic to see if this would decrease pain and stiffness while not making him drowsy, and continued Pamelor. He also recommended that he remain off work, and sent him to Dr. Butler for an evaluation of his jaw. (CX B, p.p. 31-32)

In a third letter by Dr. Birky of September 11, 1995 (CX B, p. 30), an MRI revealed spurring and spondylolisthesis with a portion of the C-5 vertebrae body that was deviating the cord. He noted "well-healed, drying shingle scabs on his left face and neck" and added "shingles" to the impressions of his previous reports. He noted that Mr. Riley misunderstood some of instructions on the medications and revised his orders on them. He continued Zostrix cream for shingles and he continued Norflex.

From Dr. Birky, in response to a form inquiry from attorney Tranter dated August 26, 1996, about Mr. Riley's condition, he stated in response to the following questions, to a <u>responsible medical probability</u>:

> 1) Were the head and neck injuries for which he was treating Mr. Riley caused by his accident of August 10, 1995? Yes;
> 2) Is Mr. Riley totally disabled from doing his regular work as a heavy equipment operator? Yes - explanation: requires too much moving, and too much head turning;
> 3) If the answer to 2) is yes, whether he is totally disabled from regular work due to head and neck injury sustained on August 10, 1995, as opposed to his cardiac condition: yes - explanation: heavy work would cause an increase in pain;
> 4) What limitations would you place on Mr. Riley's work or other activities as a result of his head and neck injury of August 10, 1995: very light duty - explanation: "He does

however have significant memory problems which would also prohibit him from many non-exertional tasks." (CX B, p.p. 26-27)

This was accompanied by a functional capacity form for MetLife Insurance as subjective systems neck and shoulder pain - dizzy, degenerative changes on the neck MRI; primary diagnosis: post-traumatic concussion and neck pain. The secondary diagnosis: coronary artery disease. The present and future course of treatment: medicine. Limitations: stairs/ladders; scaffolds/heights; with limitations on activities including transportation reaching finger dexterity; climbing; balancing; bending; operating truck dollies/small vehicle; operating heavy equipment; all of which he must "avoid completely." He also stated that there were limitations on standing, sitting, change of position (standing, sitting), reaching, pushing, pulling, twisting (arms/leg controls), grasping/handling, operating electrical equipment, and concentrated visual tension. He stated, in support, that he had full balance endurance, an extreme movement but generated dizziness. He also stated that he could lift 0-15 lbs. less than 20 percent of the time and never lift 16 lbs. or above due to persistent neck and shoulder pain. He stated that, if he failed to progress further, that he was totally disabled from this or any occupation, it could not be determined when he could return to work, and his condition was indefinite. (CX B, p.p. 28-29)

The above was repeated in a letter dated December 18, 1997, and in a report dated August 24, 1998, for an office visit illustrating new symptoms of increased unsteadiness with walking and repeated falling forward or to the left, with progressively increasing forgetfulness including when he took his medicines. There were no observed seizures for four months but he had problems with anticonvulsants. He feels remarkably weaker, his systems are significant for generalized arthritis in multiple joints, which he states is from the accident. The letters are otherwise incomplete. (CX B-1)

The letter reports from Dr. John P. Winikates, M.D. dated September 14, 1998, October 14, 1998, November 9, 1998, February 15, 1998, March 1, 1999, March 29, 1999, September 20, 1999, including June 28, 1999, progressed towards final findings which recount the serious head injuries, subsequent headaches, and vertigo, and getting worse. His arthritis continues with non-steriodal treatments, and Plaquenil 10CXA-3. He verified possible arthritis, lupus, and gout. The dual diagnostic report of March 8, revealed abnormal electronystagmogrim due to left peripheral lession, with a diagnosis of vertigo, gait imbalance and post- closed head injury. (CX B, p. 5)

In a deposition dated November 1, 1999, Dr. Winikates reviewed his neuro diagnostic report of March 5, 1999, and the EMG report of March 15, 1999. The EMG report of March 15, 1999, concluded that he had a mild left C5 radiculopathy and a possible mild axonal neuropathy with slight loss of velocity in the left peroneal and tibial nerves. These findings were probably normal, however, given the normal F-waves. (CX A, p. 8) In the next deposition (CX F), he confirmed that Mr. Riley's separate head injury would vault to the left side of his head as far as difficulty with balance, persistent headaches and memory problems.

He concluded from his reading of the history that Mr. Riley's injuries that he treated were caused by the blow to the head; resulting in persistent balance difficulties and vertigo causing difficulty with occasional unsteadiness in walking. This condition was the reason for a fall that caused an office visit that occurred early in the same day as the deposition. His condition has not responded to all the medications,

and continues to result in significant functional problems. (Ibid) It is not showing improvement, and seems to be permanent. (CX F, p. 5-6) He does not believe that Mr. Riley can perform gainful employment, and believes that it would be unsafe for Mr. Riley to be placed back in the work force, because of his balance problems, since he would not be able to function safely or effectively. (CX F, p. 6)

On cross-examination, Employer's counsel noted that Dr. Winikates had referred in the past to "give away weakness" when testing reflects the way a patient exerts himself during the strength exam, indicating the patient is not giving full effort through the entire period of testing period. (Id at 7) Dr. Winikates confirmed that sometimes the patient isn't voluntarily trying hard enough but that sometimes there is "giveaway weakness" because of pain or discomfort elicited by making the effort, noting that "you can't always tell." One did confirm that the sensory exam does depend upon the patient reporting, the way they feel and the way they don't, so it is subjective and it does not fit an anatomical pattern. It is sometimes seen with organic nerve injury but it's not "non-anatomic" and it is not "dermatonal", it's a different kind of nerve injury pattern. When asked whether he had any cause to question his feelings regarding "his findings that the patient may not be giving a full valid response," he said that he may have expected that at first, wondering whether he was really trying and so forth, but the longer he treated him, the less he felt that's really been a factor. (Id at 9) He also confirmed that while even reports of complaints of headache are 99 percent subjective, objective testing was made to test his vertigo. An EMG conducted on March 5, 1999, was attached as Exhibit B to the deposition. Also attached were EMG reports of March 11th and 15th, 1999, as Exhibit C and D thereto. He confirmed that the March 11th 1999 EEG was normal (Id at 11), but explained that in some cases a brain injury or seizures or other brain problems, there may be abnormal brain wave patterns that are present intermittently; so when testing is performed they may or may not be present. He testified that an EEG is really a very non-specific finding that does not rule out the presence of brain abnormality, but if it is abnormal, it tells you something is wrong. (Id at 11-12)

Dr. Winikates confirmed that he witnessed a staring spell or seizure in the office on March of 1999 but did not make a note. (Id at 12) Mr. Riley did not lose consciousness but appeared groggy, and he concluded he needed to re-adjust his medication. (Id at 13) He also confirmed that on the EMG (misstated as ENG) his impression was an abnormal EMG due to left peripheral lesion tend to relate to the vertigo as well as to brain waves. (Id at 13)

Dr. Winikates confirmed that he had agreed that Mr. Riley could make the trip to Louisville for the evaluation and that he might benefit from that. (Id at 14) He also stated that if there were certain jobs that would not be as physically exertional as the coal operator or equipment operator job that he had done with the Employer, and that he would be able to perform a more sedentary job, like a dispatcher job or clerical work, that he did not believe that he would have the ability to perform those jobs in that he would not be able to maintain the level of concentration or memory ability to perform them. (Id at 15)

Dr. Winikates felt that a neuropsychological exam or aptitude exam might be helpful, they could gain information from it, but when one was rescheduled by Employer's attorney, Mr. Riley refused to go. (Id at 15)[2] Dr. Winikates reviewed the medications that claimant has taken as Depakote, Flexeril, Ultram, Norvasc, Lasix, potassium, aspirin, Paxil, Xanax, and Celebrex.

Dr. Winikates confirmed that Xanax can cause light-headedness and it was one of the drugs being previously prescribed by Dr. Estes. Likewise, high blood pressure medicines such as Norvasc can cause light-headedness. It depends upon the dose and the adjustment. Xanax and Paxil could cause some memory loss. Individuals with heart conditions could experience some memory confusion, dizziness, and vertigo as a sequela of a heart condition. (Id at 18)

Dr. Winikates also confirmed he saw Mr. Riley on September 20th and drafted a letter to the effect that he could not fly due to severe vertigo and balance difficulties. This was for a vacation that he had planned (and was later cancelled. See Mrs. Riley's testimony. supra, p. 10), he did not know the details. (Id at 18-19) In that day's visit (November 1, 1999), Dr. Winikates noted that he had fallen and had a little swelling on the back of his head from a fall that took place apparently on the previous Friday. He stated that he had lost his balance, fell backward and struck his head against a piece of furniture or something; did not have other treatment or loss of consciousness in that he prescribed Midrin, a non-narcotic headache medication. No other diagnostic testing was required. (Id at 20)

Employer submitted duplicates of Dr. Birky's reports - they included the reports of August 14, 1995, August 28, 1995, September 11, 1995, November 20, 1995, March 4, 1996, April 1, 1996, September 9, 1996 and March 29, 1998. (ER EX 2, p.p. 9-28) In the report of March 29, 1998, Dr. Birky had reviewed a report from Dr. Hines stating "I basically agree with everything stated. I do feel it would be quite reasonable to have Mr. Riley try to work under the guidelines suggested by Dr. Hines. I would be less optimistic, however, that his employer could actually provide him with a position that follows a suggested guidelines. The last time I spoke with Mr. Riley - he would not have felt he was ready to return to work but perhaps things have changed."

Dr. Warren Bilkey's Report:

Dr. Birky also reviewed the report of Dr. Bilkey dated December 22, 1995, (ER EX. 3, p.p. 29-31) in which Dr. Bilkey concluded that Mr. Riley had probable post-traumatic stress disorder with mechanical dysfunction demonstrated which would be prudent to treat. (Id at 30) He stated that this could play a part in his persistent pain from early in the cervical and thoracic restrictions and the serratus myalgia, but that the latter would refer pain to the chest and may mimic a heart attack pain enough to further complicate his case. He stated that the mechanical problems were relatively mild and did not fully explain the symptoms spectrum; and that, from a mechanical standpoint, there did not appear to be a disc herniation with radiculopathy nor evidence of foraminal stenosis. He rejected surgery and observed that if a neuropathic process is present, this would explain only a small portion of the symptom spectrum. He

[2]This was performed after the hearing and the report is discussed in Dr. Conte's report.

doubted significant post-concussion syndrome, and did not see a sufficient head trauma to produce it. He felt that the greatest concern was the post-traumatic stress

syndrome which could fully explain all symptoms in which, if not treated, prove significantly disabling. He felt that there was a continuing post-traumatic stress disorder related to his Vietnam experience and "a prior injury similar to this current injury" which appears as welts and fed into the post-traumatic stress disorder.

However, in spite of the above, Dr. Bilkey stated that "the current diagnosis of post-traumatic stress disorder should be regarded as related exclusively to the work-related injury of 8/10/95. Prior untreated post-traumatic stress disorder made him more vulnerable but was itself not disabling." (Id at 30) He recommended that the matter be further evaluated by a psychologist competent in the area, that treatment recommendations be pursued, and that there should be appropriate psycho-active medication intake. He noted that Mr. Riley was on a "considerable list of these" medications and he had a concern on whether they were inappropriate.

He recommended return to work immediately after the psychological evaluation and that such treatment proceed with Mr. Riley continuing to work on a lighter duty capacity, integrating the work activities and the treatment for the post-traumatic stress disorder. He recommended that he start at a light duty occupational category, avoiding unprotected heights, and progressing to moderate duty occupational category as tolerated. (Id at 31)

On May 17, 1996, Dr. Bilkey issued another report, at the request of the insurer, Mr. Riley stated that he did see a psychologist and was told that he did not have a post-traumatic stress disorder, noting that there was no documentation that this occurred. He noted being placed on seizure medications; but they are gone but he still gets blackouts. He gets nausea with riding in a car, and his facial skin rash comes and goes. He relates problems with his left neck, back, headache and upper and lower limb. He noted the January 1996 angioplasty and that it has cured his chest pain. He takes Depakote, Ultram, Flexeril, Nortriptyline, and a diuretic and potassium supplement.

Dr. Bilkey states that there is no documentation to support the seizure disorder at this point and that there is no post-traumatic stress disorder, concluding that "if there is no documentable seizure disorder and it is true that there is no post-traumatic stress disorder, there is no indication for further medical input." He acknowledges that Depakote, in this case, would be <u>for the treatment of chronic pain</u> and would amount to a fully appropriate medication treatment trial. (Id at 32) He felt that there was no indication of further medical treatment from the musculoskeletal standpoint. He repeated that there is no documentable seizure disorder and Mr. Riley "is currently at maximum medical improvement." (Id at 33) He noted previous restrictions to light duty, avoiding unprotected heights, having maximum recommended lift of 30 pounds, and he recommended he continue without the seizure disorder. However, he recommends the input of Dr. Birky to modify the restrictions, and discuss these with the patient and his wife.

<u>Dr. Birky's Deposition</u>

Dr. Birky was deposed on November 7, 1996 (ER EX 8). After confirming his credentials, Dr. Birky testified to examination and treatment of Mr. Riley from August 14, 1995, and revealing the strike in the head by the steel cable, and his many ongoing complaints of headaches and neck pain. (Id at 4)

Along with prior x-rays of his skull and neck, and a neurological exam revealing degenerative changes in his cervical spine, he noted a history of coronary artery disease, previous heart attack and a heavy smoker. His brothers headaches were never examined. (Id at 7) He tested for sensation, strength, reflexes, balance, and range of motion of his neck, with a cranial nerve exam revealing a "mild aniseikonia," (unequal pupil size). (Id at 6) He confirmed that aniseikonia was noted to be a half millimeter difference which could be normal, so from a pathological standpoint, doesn't mean anything. (Id at 6) His motor exam, sensory exam, and reflexes were within normal limits, along with his cerebellar function. At this point, these would argue against major damage to the brain, spinal chord, or peripheral nervous system, and his diagnostic impression was that he had a cervical strain and post-concussion syndrome. (Id at 6-7) He recommended physical therapy and medications for muscle pain and headaches. He saw him later on the 28th consistent with the report of that date. (Id at 7) His shoulder pain was a little better, with headaches unchanged, but had a "scalding pain on the left side of his face, later diagnosed as shingles." (Ibid) Later, when the shingles showed as lesions, he gave him antiviral medication. (Id at 8) He confirmed that shingles many times are brought on by some type of physical or emotional stress.

Dr. Birky also wanted to refer Mr. Riley to Dr. Butler for asymmetric jaw pain. Overall, the jaw pain improved and he complained less and less about it, and, he did not think there was a big problem. (Id at 9) He saw Mr. Riley on September 11, 1995 for the results of the MRI which showed bone spurring and spondylolisthesis "in which the vertebrae move with respect to one another either anteriorly or posteriorly," with the C5 vertebral body deviating the cord. (ID at 10) This would be from degenerative changes, pre-dating the August 10, 1995 accident. (Id at 10) At this point, he switched the shingles medication due to drowsiness (Id at 11), and he next saw him on October 9th, when his headaches were better, shingles resolved, but a lot of popping sensation in his neck when he turned his head from side to side with neck pain and stiffness. (Id at 11) He again switched muscle relaxers, increased one of the other medications to "help with the chronic pain" and with insomnia. (Ibid) Gradually he came to the conclusion that Mr. Riley had soft tissue injuries. (Id at 12)

Dr. Birky saw Mr. Riley on November 20th, with neck complaints, complaints of being off balance which was interfering with his driving, and prescribed a different medication to help with dizziness and pain. (Id at 12) He did not conduct tests for dizziness and stated that it was probably subjective. (Id at 13)

On March 4, 1996, he saw him for essentially the same problems with "episodes of disorientation." For which, he obtained an EEG, having had an episode that he would characterize as a seizure. (Id at 13) He switched the muscle relaxer for something else and sent him to physical therapy. An EEG was performed the following day and was normal. (Id at 13-14) The EEG's of August 1995, and March 1996, do not rule out the possibility of a seizure but suggest no significant structural damage to the brain. (Id at 15) He said the only way to actually prove a seizure is to "coincidentally have someone hooked up to the machine when they have an event." Other than that, the diagnosis is made by history. His wife noted that after putting him on seizure medicine, he did not have any more staring spells. (ID at 17) He still had some back problems which means that he still had some neck problems. The medication made him drowsy at night. (Id at 17) Mr. Riley kept asking about going back to work, and Dr. Birky arranged for a functional capacity evaluation.

An evaluation of Mr. Riley was performed on April 4, 1996. The report indicated that he was able to carry, by using both arms, 40 pounds for about 50 feet on an occasional basis; that his average push force was 50 pounds, and pull force was right around 44 pounds; that he demonstrated an ability to work in a light to medium category, meaning carry/push/pull/lift up to 35 pounds occasionally, 17 pounds frequently, or 5 pounds constantly. (Id at 18) The evaluation mentioned the testing by appropriate professionals which resulted in a neuropsychological test by a Dr. Steven Simon, Ph.D., psychologist on July 27, 1996. (Id at 19-20)

When asked whether he had taken steps to either test or treat the dizziness or memory difficulties, concentration, etc., he stated that some of the medications were antidepressants used frequently in chronic pain situations, that could help with depression and otherwise with medication for dizziness. (Id at 21)

Dr. Birky again saw Mr. Riley on June 3rd, with the pain still present but apparently stabilizing, not getting worse or better. He was doing better with staring spells, but still having problems with balance (Id at 21), so he altered medications. This time prescribing one for dizziness, Meclizine, and an antidepressant, Nortriptyline.

On September 9th, another visit by Mr. Riley revealed headaches flaring up again, getting worse, with medications not helping. (Id at 22) That described an event as a clonic seizure where he had convulsions. (Id at 22) For this, he increased seizure medications and antidepressants, with something else for headaches.

At that point in time, November 1999, his diagnosis was that Mr. Riley had post-traumatic neck pain which is essentially the same as cervical strain, persistent headaches, persistent dizziness, but which may be grouped together as a post-concussion syndrome, or as they called it traumatic brain injury - almost the same thing, and he seemed to have an event that sounded like a seizure disorder which he called a post-traumatic seizure disorder. The latter he diagnosed, as a result of the incidents discussed earlier, that this appeared with Depakote. (Id at 24) He stated that it is hard to know the relationship of the seizures to the injury, but the fact that he was having staring spells, if they were in fact, complex partial seizures, many times they will progress into what's called a generalized seizure which clinically appears as a convulsion. This goes from a focal part of the brain to the whole brain. (Id at 24) This would have occurred a lot earlier than a year after the accident and were related. (Id at 25) He did admit that there was nothing specific, or hard data, to support brain injury or pathology about the brain as a result of the August work injury. (Id at 25)

Confirming that there were symptoms in November 1994, for dizziness, memory problems, and difficulty in concentrating which could be consistent with a stroke, he stated that the stroke would show up on an MRI. (Id at 26) In response to questions about Mr. Riley's father and brother having stroke and headaches with a possible hereditary component, Dr. Birky stated the headaches do run in families, that in the present circumstance everything seemed to occur after the accident. He admitted that some times strokes, heart disease, and headaches all run in the family. He attempted to connect these with the statement that he just sat around and stared or his staring episode back in '94, to be similar to the episodes of staring he had in '95 and '96. Dr. Birky stated that with regard to the heart attack in 1994, when someone is having a staring event during that, it is because of the damage or ongoing damage of the heart. They are not "perfusing their brain with enough blood to maintain a higher level of consciousness." He

could not state one way or the other whether there was a relationship that people could have episodes of staring and not have seizures, or things that would develop into clonic seizures. (Id at 28)

In reviewing the question of light-headedness related to the heart problems as seen by Dr. Estes in January 1995, it could also be related to stroke or stroke symptoms or light-headedness with the seizures. He also discussed other possibilities in relation to the staring episodes as attributable to his heart condition, but rejected the idea that a heart condition would lead to convulsive seizures. Other symptoms might be related to alcohol withdrawal as a percipitator of seizures, but that he wouldn't say alcohol itself caused staring spells. These would not occur years after the withdrawal. (Id at 30)

Dr. Estes' records of June 5, 1995, contain a listing of the medications that he was on at that time, and Dr. Birky was asked whether they could interact and cause staring or seizures, and he responded that he wouldn't say that they would cause seizures. Occasionally Xanax would cause some staring. (Id at 31-32)

In terms of anything else that could be done to reduce his symptoms or try to get him back to work, the only treatment that he could think of would be a nerve block for his neck, but as far as investigative studies he is not sure that he does not have anything specific. (Id at 32) This would be to relieve pain from the soft tissue injury. He felt that he could conclude, since he hasn't called the office since September, that the Depakote is controlling the seizures and staring episodes. (Id at 31-32)

With regard to medications being taken on a daily basis causing him to be drowsy or have staring spells, or problems with memory, the doctor stated that the cyclobenzaprine, a muscle relaxer, closely related to the nortriptyline, an antidepressant, can cause drowsiness enough to have staring spells. Only Xanax is known to cause drowsiness and that is an anxiety medication. (Id at 33) His only reservation is about the Xanax because it can become addictive and should be short-term rather than long-term medication. (Id at 34) When asked whether the soft tissue injury should have resolved that for a period of a few weeks or a few months, for, then, a year post injury, he responded that Mr. Riley's was longer than most, but certainly not unheard of. (Id at 35) Since it has lasted a year, Dr. Birky is skeptical that it will resolve totally. (Id at 35)

With regard to objective findings, he recalls that Mr. Riley still has a lot of tenderness in the cervical muscles, and his range of motion is still a little impaired, as well (Id at 36), even admitting that they have a subjective component to them. When asked whether he had "written this guy off in terms of trying to get him back to some kind of work activity," and whether there was some kind of sedentary work that would allow him to work within the lifting limitations that were set in the functional capacity evaluation, where he wouldn't be working with heights or having machinery, after stated he is also getting people back to work if there is an opportunity to pursue something like that would fall within some of the restrictions, he stated that Mr. Riley had reached his maximum medical improvement. (Id at 37) He set the date of maximum medical improvement as around June 3, 1996, when "things finally plateaued." (Id at 37)

On cross-examination, referring to the August 26, 1996 questionnaire with an appended report, Dr. Birkey was asked for an opinion as to whether the head and neck injuries for which he was treating Mr. Riley were caused by the accident of August 10, 1995, and to that he said "yes." (Id at 40-41) He also stated that there was not enough other evidence at this point to support a stroke as a cause for his problems, noting that stroke, as a rule, tends not to cause headaches and neck pain. (Id at 41) He testified that all of the symptoms started following the accident, and didn't really express any pre-existing problem like this before, so he had to conclude that it was from his accident. (Id at 41) He reviewed his final diagnosis as "post-traumatic neck pain" (Id at 41) essentially the same as cervical strain with the post-traumatic part specifying that it is from trauma and not some sort of bending accident. (Id at 42) It was his opinion that the neck injury was from the August 10, 1995 accident (Id at 42) and degenerative changes indicated would not have been caused by the accident but any underlying condition of the neck may predispose one to have more symptoms from a set accident than you might have if your underlying neck structures were normal. (Id at 42) Expounding on the injury diagnosis, he testified that he was calling Mr. Riley's problem a "post-concussion syndrome" which they believe implies a problem with headaches, sometimes light-headedness, sometimes dizziness, and memory changes, trouble with concentrating, even trouble with change in personality at times, which isn't necessarily any different than a traumatic brain injury. Again, the diagnosis of post-concussion syndrome and the symptoms described were caused by the August 10, 1995 accident. (Id at 43) He testified that Mr. Riley is presently disabled from doing his regular work as a heavy equipment operator, and would be unable to perform that duty because it would involve too much moving around and too much head turning that he could not do, and the head turning would cause him pain, which he could not do. (Id at 43-44) In terms of limitations he would place on Mr. Riley's work as a result of the August 10, 1995 injury, he felt that he was limited to very light duty work, eliminating exertional tasks and because of some memory problems and control of concentration, with some of the more intellectual or cognition-requiring jobs, he would have difficulty with that too, even though non-exertional. (Id at 44-45) He stated that his opinions of August 26, 1996, were the same on November 7, 1996. (Id at 45) He had since reviewed a neuropsychological report and it did not change or alter his opinions. (Id at 45) He finds those opinions of Dr. Simon to be consistent with his own. (Id at 45)

In response to further re-direct questions, he stated that it was his opinion that they could rule out familial or idiopathic causes to the head injury component since no one has provided a clear, longstanding history of headaches, which should be present in the familial situation. It would be unusual for those to start at the age of 53, (Id at 46) as being attributed to being inherited. When asked about certain tests coming back normal such as the EEG's, MRI's, and CT scans, he would only say that it was not severe enough to physically cause damage that you could pick up on those scans. He also stated that someone could be knocked out or unconscious for hours, and he may not ever see a specific abnormality or secure the injury they may start to get edema or hemorrhage which "sometimes you may only pick up if – if the scan was performed immediately." (Id at 48) Otherwise, months to weeks down the road, all those changes would resolve. (Id at 48) Therefore, it is possible to have various head injuries at some point later on, or even immediately, and not have any specific abnormalities that you see on the studies. (Id at 48) He confirmed that he did not see any evidence of hemorrhaging or hematoma in Mr. Riley's case. (Id at 49-50) Concussions could still resolve with time, but he is becoming more and more skeptical that that will actually happen in Mr. Riley's case. (Id at 50) He can not judge or quantify the level of dizziness or light-headedness with regard to Mr. Riley. (Id at 50) He did state that degenerative changes that were picked up does not have any complaints about them at the time of the work injury. He would characterize the

changes that took place as "being a dormant, nondisabling condition which was aroused to a disabling reality by the work injury. (Id at 50)

He also confirmed that Mr. Riley should be able to perform the activities outlined in the functional capacity evaluation. With regard to shipping and receiving clerk, dispatcher, parts clerk or a job sitting at a desk working on the computer. He might be able to do them physically but looking at the head injury, that might have affected his ability to concentrate. He could refrain from using some of his medications. (Id at 51)

However, he noted on re-direct examination, while it is a good idea to analyze medications, in Mr. Riley's case each one of the medications seems to still be necessary at this point and have a specific need. (Id at 52) He notes that he takes both Relafen and Daypro, almost the same thing, and might consider dropping one of those. (Id at 53-54)

Dr. William H. Estes, M.D.

In the November 14, 1994 discharge summary for the hospitalization at Kings Daughters Hospital, for November 17, 1994 through November 14, 1994, Dr. Estes, indicates a diagnosis of coronary artery disease, recommended for medical management, hypertension, anxiety, and depression, with the admitting diagnosis being unstable angina. (ER EX 4, p.p. 34-66) Mr. Riley was 50 years old at the time and was admitted with chest pain and palpitations, and related some of that to possible substance abuse disorder with alcohol and tobacco abuse problems. He recommended the catheterization and echocardiogram that revealed only a sinus tachycardia with serial electrocardiograms which were normal without evidence for ischemic heart disease. (Id at 34) The catheterization revealed long 50% stenosis of the right coronary artery but no evidence for cortical stenosis. He was moved out of Intensive Care, put on medications and released. The medications included Xanax, Paxil, Norvasc, and Ecotrin. (Id at 35)

Mr. Riley was seen again by Dr. Estes on January 23, 1995, with an assessment of chest pain, a CAD with a 50% LAD lesion, and chronic tobacco abuse. His medications included Norvasc, aspirin, Lodine, Nitrostat and Paxil. He was allowed to return to work without restrictions.

He was seen again on March 27, 1995, with a similar assessment of doing reasonably well but having a lot of chest pains and under a lot of stress lately on the job. The same medications applied. (Id at 36-37)

Dr. Estes saw Mr. Riley on June 23, 1995, with no angina, and not taking sublingual Nitro. He was working full time and overall medication has been working well. The medications remaining approximately the same. (Id at 38)

On January 16, 1996, however, Mr. Riley saw Dr. Estes with chest pain off and on for a few days rather atypical. (Id at 39)

Resulting tests showed an abnormal stress cardiolyte scan with defect, along inferior left ventricular wall consistent with small infarction and coronary ischemia. (Id at 55 and 57)

February 26, 1996, notes show as the assessment, status post angioplasty of LAD 196, chronic tobacco abuse and anxiety, and problems with his left side due to the injury. His wife stated a belief that he had a light stroke on the left side of the face - it looked a little drawn. Along with the Xanax, aspirin, Paxil or Norvasc, he increased the Paxil and scheduled him for a MRI of the head. (Id at 40) On May 9, 1996, he noted increased weight gain and fluid retention, and Lasix was added to the medications. (ID at 41)

On June 14, 1996, he found no major problems in terms of a heart disease or chest pain; smoking continued to be a problem with ankle swelling and stiffness, and he obtained an appointment with rheumatologist Dr. Eshan for an evaluation.

An evaluation of July 3, 1996, by Dr. Eshan Moshen for Dr. Estes revealed seronegative symmetrical arthritis, more suggestive of RA (rheumatid arthritis) rather than psoratic arthritis but is uncertain. He added Ecotrin and Plaquenil to medications with moist heat joint protection. (EX 43)

The last notes of Dr. Estes for September 19, 1996, and October 3, 1996, covered cough, congestion, wheezing resolving by October, continuation of current medicines with Rocephin, being added. Depo-Medrol and Cefzil added with a Prednisone "taper". (Id 44-45)

Also included was the above cardiolyte scan of January 19, 1996. (Id at 55) A head MRI on February 27, 1996, revealed deep white matter seen as spots consistent with commonly seen small areas of gliogenous secondary to ischemic, and encephalomalacia or abnormality, and no lesion or abnormality to the brain. (Id at 60)

A chest x-ray of May 9, 1996, revealed no new cardiac or pulmonary abnormality with some post-inflammatory changes in apices and pleural thickening. (Id at 62)

The emergency room record of August 10, 1995, revealed as a final diagnosis contusion/abrasion to head and neck sprain - spurring founded by Dr. Kearselin. (CX EX 5, p. 85)

Historically, notes regarding upper quadrant pain consistent etiology undetermined go back as far as January 17, 1979. (ER EX 5, p. 67 by Dr. H.S. Riley, M.D.) In an IVP for kidney stones on January 18, 1979, no urographic abnormality was identified. (Id at 68) Other history and treatment notes were not related. (EX 5, p.p. 69-70) The history and physical of November 14, 1994, (ER. EX 5, p. 76) revealed chest pain possibly angina and noting that he smoked 3+ packs of cigarettes per day, with coronary artery insufficiencies, (Id at 77) and a cardiac catheterization and coronary arteriography with a left ventriculography were also performed. (Id at 78) The right coronary artery revealed the 50% stenosis noted above. (ID at 78)

Scans and x-rays of the skull on August 10, 1995, through August 29, 1995, revealed: no fracture or evidence of intracranial pathology; (EX 5, p. 91) degenerative changes to the cervical spine (C5-6); narrowing the small anterior and posterior marginal spurring with minimal encroachment on the intervertebral foramina at C5-6 bilaterally from small spurring at uncovertebral joints, (Id at 91) on the reports of August 10, 1995; no form of intracranial hemorrhage and no sign of infarction, space occupying lesion nor evidence of fracture, on August 11th, on a tomography, and CT scan; (Id at 90); no degenerative disc at C5-6 confirming findings of August 10th, but with minimal reverse spondylolisthesis at C5-6, on an August 26, 1995 MRI; and posterior spurring at C5, minimally deviating the cord posteriorly. (Id at 89)

A KDH Rehab Center report of April 4, 1996, stated that claimant demonstrated working in a light to medium level of work period with lifting, carry, push/pulling 35 pounds occasionally, 17 pounds frequently, or 5 pounds on a continuous basis. On the job as coal equipment operator, to be classified as medium level of work, it stated the client's demonstrated physical capacity does not meet physical demand level of his job. It is not recommended that he return to work at his previous job at his previous condition, and stated the following functional limitations: 1) constant neck and left arm burning pain and left arm numbness; 2) limited cervical range of motion due to muscle tightness and pain; 3) tender upon palpation throughout; 4) frequent occipital and frontal headaches; 5) left elbow medial occipital and frontal headaches; 6) left first MCP joint strain; 7) limited left shoulder range of motion and strength when compared to right; 8) decreased sensation to light touch from left elbow to hand and left knee to foot; 9) positive thoracic tested bilaterally with absent radial pulse; 10) poor posture awareness as evident in sitting, standing and functional activities; 11) limited lumbar range of motion in all planes by apparent muscle tightness; 12) poor unipedal standing balance, right 10 seconds and left 15 seconds; 13) difficulty in squatting, crouching and kneeling due to right knee pain and lower extremity weakness; 14) dizziness and loss of balance when rising from squatting, crouching, kneeling and bending positions; 15) positive McMurray's testing of right knee with reproduction of clunk and pain - possible meniscal involvement; and 16) poor concentration and attention span with majority of testing - further testing required. Summarizing, the reporting therapist noted a good correlation between his pain rating and observed behavior during testing, observing that body mechanics and material handling ability were poor, and observed gross coordination was poor. (ID at 103-104) As stated above, the exam was April 4, 1996, on referral by Dr. Birky.

A psychiatric evaluation was performed on July 27, 1996, which involved a clinical interview and testing. (CX 6) The evaluation resulted in the following diagnostic impressions: Axis I: Organic Personality Disorder; and Depressive Disorder, and Axis II: No diagnosis; and Axis III: Postconcussion Syndrome; status post 11/94 heart attack and 1/96 cardiac surgery; reported history of rheumatoid arthritis; seizure disorder: secondary to head injury; and cervical strain. (ID at 111)

While Mr. Riley was able to understand directions and follow through and able to cooperate reasonably well with others, and presents with no signs or symptoms of psychiatric dysfunction, he appears "to have significant impairment with respect to verbal recall and ability to retain newly learned information (i.e., Delayed Recall). Pyschomotor speed, learning ability and visual attention were also found to be impaired according to the TrailMaking Test. Also, his depressive sequelae appeared to be a compromising

factor, with Mr. Riley reporting symptoms of depression, concern over physical problems, irritability and anergia. (Ibid)

Scott D. Hines, M.D.

On November 18, 1997, Scott D. Hines, M.D., a physician for neuroscience associates, P.S.C. conducted an independent medical evaluation of Mr. Riley. (CX D, p. 44-49, ER EX 1, p. 2-8) In addition, Dr. Hines issued a letter to the attorney for the Employer dated January 27, 1998. He questioned the work capability of Mr. Riley pursuant to the November 18, 1997 evaluation discussed above. In the January 27th letter, he stated that he does believe that Mr. Riley has a "real" closed head injury, that the work itself would not aggravate the condition or lead to increasing disability. He doubts that he is capable of a skilled employment that he was previously involved in, but could do a "simple, repetitive type of activity with allowances made for decreased concentration, an[d] increased amount of fatigue ability." He finds that people working long term do better in terms of fighting depressive syndrome, to do some type of work, even a simple mechanical activity than those who stay home. However, he also stated that the work environment that he would be involved in the future should, of course, be accommodating; meaning, "breaks every hour, such as 10-15 minute breaks, with the realization that he may be a little "slow" at first until he gets used to the job."

It is my opinion that this particular limitation of "breaks every hour" would eliminate all jobs for purposes of disability consideration. Such requirements allow such breaks every two hours during the course of the day, and requiring one every hour would permit them to refuse to hire or continue to employ such a worker.

After reviewing the prior reports, Dr. Hines found that Mr. Riley "does have some legitimate complaints related to closed head injury," . . . [including] . . . trouble with concentrating, poorly defined, throbbing headaches, difficulty with dizziness and post positional vertigo, and depression . . . . They fit "a legitimate case of closed head injury." He has shown some improvement but has plateaued and he doubts he will get any significant neurological improvement in the future. (Id at 47)

Mr. Riley has some left arm numbness and slight weakness, tainted with some functional overlay but he suspects some mild C5/C6 radiculopathy and arthritis/spondylosis of a pre-existing nature, likely aggravated by the injury. (Id at 47)

Mr. Riley was having dizziness, appearing orthostatic hipotension in nature with suspected aggravation by medications that he was "appropriately" put on, but may have which have orthostatic (standing) nature including Pameral (specifically Flexeril and even Xanax). He is doing better but has some positional vertigo which is probably post-traumatic in nature. He has some significant depression appropriately treated with Paxil and Pamalar, and feels that counseling would persist. Mr. Riley has slightly diminished blood flow in the left arm which is not permanent in nature, but which contributes a bit to some weakness of the left side as a non-major issue. He has evidence of clinically mild S1 radiculapathy on the left side edited to be related to the trauma but more of a problem since he has had weight gain. His physical therapy and other conservative measures including weight loss. (Id at 48) Depocode is likely to increase appetite and needs strict dietary measures to overcome it.

By history, Mr. Riley had generalized convulsive episodes which can occur following a head injury, but unlikely to be a long term matter. He may have even had complex partial seizures, but no evidence of current repetition. It appears to have helped. They recommended further scans, to determine whether the head neuropathology might be malignant in nature, falsely attributed to the head trauma, therefore suggesting an MRI scan of the brain. He is stable neurologically and will not show significant improvement in the near future. Major issues continue to be a closed head injury with trouble concentrating as well as positional dizziness. There is evidence of C5/C6 radiculapathy on the left side, some depression, recurrent seizures on control with Depocote, the thing is not likely to be related to head trauma include the left side sciatica, orthostatic hypotension (indirectly medication related) fasper? insufficiency. Depression is significant. (Id at 49)

Acknowledging that to present his disability is difficult, utilizing the American Medical Guidelines of 1990, finds the diagnosis disabilities of 5% for mild spinal cord injury, 25% for closed head injury based upon the impairment of complex cerebral functions such as daily activities, needs some supervision and/or directions (its because he could drive or do previous type of work including a tendency toward dizziness vertigo), and depression which contributes another 7.5% disability, possibly treatable with progressive follow-up but aggravating some other complaints. He assigns no permanent disability to the seizures since they appear to be under control. He noted as an Addendum that Mr. Riley's neuropsychological testing confirmed what he suspected, he has postconcussion syndrome, as well as depressive order, and that does not change his opinion. (Id at 49)

Deposition of Luca E. Conte, Ph.D.

Luca E. Conte, Ph.D, was called on behalf of Employer for a deposition on November 12, 1999. Mr. Tranter, for the Claimant, objected to the basis 20 C.F.R. § 702.408, et al. based upon the allowance for medical evaluation regarding wage earning capacity of an injured employee to be done by impartial examiner selected by the District Director. The Employer responded that the Longshore Act fairly allows the Employer to obtain its own independent expert, which Dr. Conte is, so the objection was overruled. (CX CPP 36-43, ER EX 9)

Dr. Conte reviewed the records through November to relate in his report on November 11, 1999. Having established his credentials (Id at 2-4) and attached as Exhibit 1, Dr. Conte indicated that he reviewed the records related to the injury sustained by Mr. Riley on August 10, 1995, including office notes and medical records of Drs. Birky, Bilkey, Estes, Hines, and Simon, Ph.D, and one Winikates to review Mr. Riley's 9/30/96 deposition, records from King's Daughters Hospital including a Functional Capacity Evaluation (FCE) dated April 4, 1996. He reported the history of the above accident and the reports set forth above, as well as the report and evaluation by Dr. Hines.

Dr. Hines found Mr. Riley capable of simple repetitive work which allows for decreased concentration and fatigue from the Function Capacity Evaluation of April 4, 1996, recognizing that he could not return to his prior occupation. Mr. Riley's limitations of low average IQ, seventh grade math skills, decreased psychomotor and general memory functions are affected by a diagnosed depressive disorder.

However, Dr. Conte found that Mr. Riley's deposition showed recent long term memory with good to excellent communication, and verified the findings that he retained vocational capacity within light-medium exertional levels and ability. He also found that the attention required by the exam itself would allow him "to attend to at least moderate tasks requiring concentration, attention to detail, and cognitive functioning. He therefore found that relating to the discussions provided by Dr. Hines and Dr. Birky, it is his professional opinion that Mr. Riley is capable of at least sedentary to light occupations, with limited demand for sustained physical or cognitive intensity. (ID at 2) Examples of jobs which exist within these limits include some teacher's aides; cashiers; retail salespersons; assorted clerical workers, including phone clerks, bookkeeping and accounting assistants, general office clerks, some dispatchers, various order clerks, various food service workers, including cashiers, counter attendants and some food preparation workers; some light machine operators and tenders; bench assemblers and hand workers; some service station cashiers; parking lot attendants; and some hand packers and packagers. Earnings in these occupations range from $5.15 per hour for entry level cashiers to $10.00 per hour for dispatchers, machine operators and some assemblers. (Id at 2-3)

He notes prospects for re-employment are much stronger during periods of low unemployment and that such has existed in both the national and regional economies in the last ten years, and he finds the likelihood for re-employment of individuals who are actively seeking jobs remain high. (Id at 3) I note that no specific jobs from specific companies were mentioned in this report.

J. Thomas Davis, Psy.D.

J. Thomas Davis, Psy.D., met with Ronald Riley on December 10, 1999, and issued a report dated December 14, 1999, pursuant to orders at the hearing and were received into evidence as Claimant's Exhibit G. This included a 60 minute clinical interview with Mr. Riley and his wife present, vocational testing, psychological testing, neuropsychological testing, and others including the Logical Memory Subtest and Wechsler Memory Scale-Revised test. He also reviewed documents submitted above, including those of Drs. Winikates, Birky, Simon (Ph.D.), Hines, Bilkey, Estes, Conte (Ph.D.), and the depositions of Mr. Riley and Drs. Winikates and Birky. He recounts the above reports including those at King's Daughters Hospital. Mr. Riley's complaints at the time of the evaluation: 1) "headaches virtually all the time"; 2) "dizzy spells"; 3) cervical pain, and 4) memory problems. He was not involved in underlying treatment at the time of the evaluation. He claims that after three months, "it wasn't doing no good", so Dr. Winikates stopped the treatment. At the time of the evaluation, Mr. Riley was still on Xanax, Paxil, K-Dur, Norvasc, Ekogin, Lasix, Celebrex, Depakote, Flexeril, and Ultram. (CX EX G)

After reviewing the records set forth above, and capsulizing their findings, he related his personal history and gave his own observations in that he was accompanied by a wife and a family of friends; that he drove himself to the evaluation, that he was somewhat overweight, and dressed casually, yet neatly in jeans, sport shirt etc., wore glasses; he ambulated slowly and somewhat stiffly, complaining of the arthritis; noting some difficulties recalling relevant historical data; relating appropriately to the examiner with slightly retarded cognitive processing speed in general; but appeared to put forth adequate effort during the objective testing and the clinical interview, and discussing the results of his evaluation. He stated that he could no longer walk much; felt a lot of the arthritis since the accident; could no longer drive because of

his sense of balance. He is unable to do a list of activities because of pain, and his life has changed and he is unable to have sex with his wife. (Id at 4)

On the Neurobehavioral Cognitive Status Examination (NCSE) he fell well within the normal average range in all areas assessed except for memory where he fell into the moderately impaired range, with some erratic performance on focused attention. Trail Making Tests Part A & B, he fell at the cutoff for probable organic dysfunction, or in the "borderline" range, and the 47th percentile in age-graded norms. However, on part B, the test revealed significant impairment exceeding the probable cutoff by 119 seconds, falling at less than the 10th percentile.

On the Letter Cancellation Task, he was also in the impaired range as reflected by an inordinate amount of time required to complete the task (i.e., a 2 minute task with a minimal of 2 errors taking 4 minutes, 25 seconds with 5 errors). (Id at 5)

On the Controlled Oral Word Association Test, regarding the ability to produce spontaneous speech fluently, it fell within the average range and 30th percentile, as adjusted. (Id at 6)

Logical Memory Land subtests of the Wechsler Memory Scale fell within the low range at 34th percentile while as in Logical Memory I, while on Logical Memory II (delayed recall) it fell in the mildly impaired range at the 9th percentile. (Mr. Riley was unable to recall any information from the first story presented him, while he was able to recall enough information from the second story to result in at least "mildly repaired" overall performance on the task.) (Id at 6)

Career Ability Placement Survey (CAPS), an aptitude battery of eight five-minute tests, he received scores of 1-4 on the eight tests, with 6 of the 8 scores below-average range and 3 falling at the lowest stanine possible. (8 vs. 9?)

MMPI-D30, assessment of syndronal depression, noted a Raw Score of 17 which converts to a T-Score of 77, which does indicate the presence of clinical level depression. (Id at 7)

In summary, the various professionals all acknowledged sequalae of closed head injury and documented on neuropsychological testing performed by Dr. Simon. Treatment had been conservative as would be expected, consistent with medication management, and some physical therapy, he has been unable to return to employment, he noted a high school education; no technical or vocational training; work history has been primarily as an equipment operator, with all skills learned on the job. (Id at 7) No assessments of ability to perform work-related activities has suggested he is capable of performing work within the light and medium range of exertional ability, with a maximum lifting of 35 pounds by Dr. Conte, and capable of at least sedentary to light occupations with limited demand for sustained physical or cognitive intensity. (Id at 7) But beyond this, he states that the aptitude testing revealed limited potential for re-entry to the work force based solely on work aptitudes as recounted above. Of particular importance, is the poor Perceptual Speed and Accuracy and Manual Speed and Dexterity as these reflect difficulties with "pace" which will present significant barriers in return to any occupation where he will be perceived as "slow" with regard to productivity. He finds that the current neuropsychological tests are consistent with the history of closed head injury and reflect common problems associated with mild to moderate closed head injury, his difficulties with concentration and memory, reduced overall cognitive processing speed, and personality change. The tests also reveal ongoing depressive symptomatology and have adverse complications. (Id at 8)

From this he concludes that Mr. Riley is incapable of returning to his prior form of employment, and further is incapable of returning to any gainful employment. His opinion is based on the symptoms presented by Mr. Riley and documented in his medical records as well as performance on current psychological, neuropsychological, and vocational testing. This prognosis for improvement is poor and it is his opinion that he is permanently and totally disabled from further gainful employment. (CX G, p. 5-8)

Dr. Luca E. Conte's report of January 18, 2000, supplements his report of November 11, 1999, as stated above. (ER EX 10) It is based upon a review of the records and the additional evaluation on January 7, 2000, which he also examined the additional records that were submitted at the hearing of Dr. Birky and Dr. Winikates, as well as a deposition of Dr. Winikates, a report of Dr. Davis, and the United States Department of Labor transcript (the present transcript) in this case. He concluded in the occupational analysis and opinions that those affected his vocational function all in his personal testimony and the tests, demonstrate excellent short and long term memory capacity, verbal skills, FCE's - physical capacities. He states:

> While I certainly do not deny that Mr. Riley may have sustained some level of cognitive impairment from his original injury, the above test results confirmed that he retains considerable vocationally relevent academic skills and physical capacities which are quite transferrable to the occupations already cited. (Referring to his prior report). (ER EX 10, p. 3)

It does not, however, discuss the "cognitive impairment" that he does not deny, and concentrates solely on the capacities that Mr. Riley has without blending them or associating them with the cognitive limitations.

With regard to Mr. Riley's diverse physical complaints, Dr. Conte saw no evidence on the record to substantiate their existence or the direct relationship to the injury. (Ibid) He also states that beside the "reported balance difficulties, there is no medical evidence or testimony which precludes Mr. Riley from work activities for strictly physical reasons," finding that the physicians who do question his capacity for employment base it primarily on "presumed limited memory and concentration capacity (e.g., Dr. Winikates; 11/1/99)". (Id at 4) He states that Claimant "should therefore be capable of performing select jobs in the sedentary to light exertional categories which do not subject him to balance-related risks." (Ibid)

Dr. Conte identifies job classifications in Lexington, Kentucky and Cincinnati, Ohio that Mr. Riley could perform, with general wage rates for dispatchers, order clerks, cashiers, and general office clerks. (Ibid) [Note: Again, he does not mention any specific jobs with any particular employers or companies in the Lexington, Kentucky or Cincinnati, Ohio area.] To justify his positions for his different analysis and conclusions, he suggests consideration of limitations on the standard testing including: 1) level of effort; 2) predictive validity; and 3) contextual factors. The level of effort recites "interfactors" which underestimate his capacity stating that they can estimate his lowest rather than highest level of functioning. Utilizing Dr. Davis' report of 12/14/99, "Results of current psychological testing reveal ongoing depressive symptomology (p.8)." In addition, he considered the demanding length of tests administered; the medications; the nature of his disability and his motivation.

With regard to predictive validity, he notes that the psychometric tests administered were designed for clinical/treatment purposes being "primarily descriptive/diagnostic in nature, reflecting a person's status only at the time of examination." (I.e., Dr. Simon, p. 4) He compares them to physician's x-rays, correlated with clinical findings, observing that "while a Full Scale IQ score can tell us that a person is functioning at a "low average" level of intelligent, it cannot predict how well the person will do vocationally, socially or even academically with any reasonable level of certainty." He then goes on to state that while he concurs "that certain psychometric tests have identified possible cognitive impairments," he does "not believe that they predict future incapacity, nor take into consideration the likelihood of future compensatory and/or adaptive mechanisms. [In other words, Dr. Conte is speculating that at some indefinate time in the future, Claimant's performance could be better. Specific case law on this point recognizes current disability rather than future possibilities and those are the circumstances and cases that govern this matter.]

With regard to the last item, "contextual factors," he states that he is most impressed by the differences of performance of persons with disabilities on "paper and pencil tests" versus real environments. He noted that some proved successful in learning and maintaining competitive employment. It is his experience that the failure of these written tests are due in large part due to the absence of motivational factors found in the real world context. He states "in Mr. Riley's case, such factors are absent from the clinical test environment, indicating a high likelihood of failure to fully recruit–or measure–his full capacities." In such a statement with no supporting documentation, I find this statement to be so speculative about the future as to warrant its being given little weight. He goes on to state that his improved test results on his current examination indicates full cognitive capacity most likely to be underestimated.

[I find this speculative statement to also be unsupported by documentation and warrants giving little weight to his opinion.]

Conclusions of Law

In arriving at a decision in this matter, the Administrative Law Judge, is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it, and he is not bound to accept the opinion or theory of any particular medical examiner. **Banks v. Chicago Grain Trimmers Association, Inc.**, 390 U.S. 459 (1968), *reh. denied*, 391 U.S. 929 (1969); **Todd Shipyards v. Donovan**, 300 F.2d 741 (5th Cir. 1962); **Scott v. Tug Mate, Incorporated**, 22 BRBS 164, 165, 167 (1989); **Hite v. Dresser Guiberson Pumping**, 22 BRBS 87, 91 (1989); **Anderson v. Todd Shipyard Corp.**, 22 BRBS 20, 22 (1989); **Hughes v. Bethlehem Steel Corp.**, 17 BRBS 153 (1985); **Seaman v. Jacksonville Shipyard, Inc.**, 14 BRBS 148.9 (1981); **Brandt v. Avondale Shipyards, Inc.**, 8 BRBS 698 (1978); **Sargent v. Matson Terminal, Inc.**, 8 BRBS 564 (1978). At the outset it further must be recognized that all factual doubts must be resolved in favor of the claimant. **Wheatley v. Adler**, 407 F.2d 307 (D.C. Cir. 1968); **Strachan Shipping Co. v. Shea**, 406 F.2d 521 (5th Cir. 1969), **cert. denied**, 395 U.S. 921 (1970). Furthermore, it has been held consistently that the Act must be construed liberally in favor of the claimant. **Voris v. Eikel**, 346 U.S. 328 (1953); **J.V. Vozzolo, Inc. v. Britton**, 377 F.2d 144 (D.C. Cir. 1967). Based upon the humanitarian nature of the Act, claimants are to be accorded the benefit of all doubts. **Durrah v. WMATA**, 760 F.2d 320 (D.C. Cir. 1985); **Champion v. S & M Traylor Brothers**, 690 F.2d 285 (D.C. Cir. 1982); **Harrison v. Potomac Electric Power Company**, 8 BRBS 313 (1978).

The Act provides a presumption that a claim comes within the provisions of the Act. **See** 33 U.S.C. §920(a). This Section 20 presumption "applies as much to the nexus between an employee's malady and his employment activities as it does to any other aspect of a claim." **Swinton v. J. Frank Kelly, Inc.**, 554 F.2d 1075 (D.C. Cir. 1976), ***cert. denied***, 429 U.S. 820 (1976). Claimant's uncontradicted credible testimony alone may constitute sufficient proof of physical injury. **Golden v. Eller & Co.**, 8 BRBS 846 (1978), *aff'd*, 620 F.2d 71 (5th Cir. 1980); **Anderson v. Todd Shipyards**, *supra*, at 21; **Miranda v. Excavation Construction, Inc.**, 13 BRBS 882 (1981).

However, this statutory presumption does not dispense with the requirement that a claim of injury must be made in the first instance, nor is it a substitute for the testimony necessary to establish a "*prima facie*" case. The Supreme Court has held that a "*prima facie*" claim for compensation, to which the statutory presumption refers, must at least allege an injury that arose in the course of employment as well as out of employment." Moreover, "the mere existence of a physical impairment is plainly insufficient to shift the burden of proof to the employer." **U.S. Industries/ Federal Sheet Metal, Inc., et al., v. Director, Office of Workers' Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1318 (1982), *rev'g* **Riley v. U.S. Industries/ Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). The presumption, though, is applicable once claimant establishes that he has sustained an injury, **i.e.**, harm to his body. **Preziosi v. Controlled Industries**, 22 BRBS 468, 470 (1989); **Brown v. Pacific Dry Dock Industries**, 22 BRBS 284, 285 (1989); **Trask v. Lockheed Shipbuilding and Construction Company**, 17 BRBS 56, 59 (1985); **Kelaita v. Triple A. Machine Shop**, 13 BRBS 326 (1981).

To establish a *prima facie* claim for compensation, a claimant need not affirmatively establish a connection between work and harm. Rather, a claimant has the burden of establishing only that (1) the claimant sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which could have caused the harm or pain. **Kelaita**, *supra*; **Kier v. Bethlehem Steel Corp.**, 16 BRBS 128 (1984).

Once this *prima facie* case is established, a presumption is created under Section 20(a) that the employee's injury or death arose out of employment. To rebut the presumption, the party opposing entitlement must present substantial evidence proving the absence of or severing the connection between such harm and employment or working conditions. **Kier**, **supra**; **Parsons Corp. of California v. Director, OWCP**, 619 F.2d 38 (9th Cir. 1980); **Butler v. District Parking Management Co.**, 363 F.2d 682 (D.C. Cir. 1966); **Ranks v. Bath Iron Works Corp.**, 22 BRBS 301, 305 (1989).

If the employer presents "specific and comprehensive" evidence sufficient to sever the connection between a claimant's harm and his employment, the presumption no longer controls, and the issue of causation must be resolved on the whole body of proof. *See, e.g.*, ***Leone v. Sealand Terminal Corp.***, 19 BRBS 100, 102 (1986); *Del Vecchio v. Bowers*, 296 U.S. 280, 286 (1935); ***Volpe v. Northeast Marine Terminals***, 671 F.2d 697, 700 (2d Cir. 1981). In such cases, I must weigh all of the evidence relevant to the causation issue, resolving all doubts in Claimant's favor. ***Sprague v. Director, OWCP,*** 688 F.2d 862, 865 (1st Cir. 1982); ***MacDonald v. Trailer Marine Transport Corp.***, 18 BRBS 259, 261 (1986). However, if Employer offers substantial evidence disproving causation thereby destroying Claimant's presumption, and I find that the evidence offered

by both Claimant and Employer is in equipoise, Claimant's claim will fail since he no longer has the benefit of the "true doubt" rule. ***Director, OWCP v. Greenwich Collieries***, 114 S.Ct. 2251, 2259 (1994).[3]

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by § 20(a). *See* ***Smith v. Sealand Terminal***, 14 BRBS 844 (1982). Rather, the presumption must be rebutted with specific and comprehensive medical evidence proving the absence of, or severing, the connection between the harm and employment. ***Hampton v. Bethlehem Steel Corp.***, 24 BRBS 141, 144 (1990). If the administrative law judge finds the Section 20(a) presumption is rebutted, he must weigh all the evidence and resolve the causation issue based on the record as a whole. ***Kier,* supra**; ***Devine v. Atlantic Container Lines, G.T.E.***, *et. al.*, 25 BRBS 15, 21 (1991). When the evidence as a whole is considered, it is the proponent (Claimant) who has the burden of proof. *See* ***Director, OWCP v. Greenwich Colleries***, 114 S.Ct. 2251, 28 BRBS 42 (CRT) (1994).

In the present case, Claimant alleges that the harm to his body, *i.e.*, the permanent effects of an injury to his head, on August 10, 1995, resulted when a cable holding a barge to another barge at the Employer's coal dock on the Ohio River, snapped loose, and caught the right side of his head at the temple. The cable projected him some 10 -14 feet in the air to the bow of the barge, causing the head injury, and the evidence verifies the stipulations regarding the basic injury. Thus, Claimant has established a *prima facie* claim that such harm is a work-related injury, but the Employer challenges the present effects, if any, as having been caused by that injury, as shall now be discussed.

The term "injury" means accidental injury or death arising out of and in the course of employment, and such occupational disease or infection as arises naturally out of such employment or as naturally or unavoidably results from such accidental injury. *See* 33 U.S.C. §902(2); **U.S. Industries/Federal Sheet Metal, Inc., et al., v. Director, Office of Workers Compensation Programs, U.S. Department of Labor**, 455 U.S. 608, 102 S.Ct. 1312 (1982), **rev'g Riley v. U.S. Industries/Federal Sheet Metal, Inc.**, 627 F.2d 455 (D.C. Cir. 1980). A work-related aggravation of a pre-existing condition is an injury pursuant to Section 2(2) of the Act. **Gardner v. Bath Iron Works Corporation**, 11 BRBS 556 (1979), *aff'd sub nom***. Gardner v. Director, OWCP**, 640 F.2d 1385 (1st Cir. 1981); **Preziosi v. Controlled Industries**, 22 BRBS 468 (1989); **Janusziewicz v. Sun Shipbuilding and Dry Dock Company**, 22 BRBS 376 (1989) (**Decision and Order on Remand**); **Johnson v. Ingalls Shipbuilding**, 22 BRBS 160 (1989); **Madrid v. Coast Marine Construction**, 22 BRBS 148 (1989). Moreover, the employment-related injury need not be the sole cause, or primary factor, in a disability for compensation purposes. Rather, if an employment-related injury contributes to, combines with or aggravates a pre-existing disease or underlying condition, the entire resultant disability is compensable. **Strachan Shipping v. Nash**, 782 F.2d 513 (5th Cir. 1986); **Independent Stevedore Co. v. O'Leary**, 357 F.2d 812 (9th Cir. 1966); **Kooley v. Marine Industries Northwest**, 22 BRBS 142 (1989); **Mijangos v. Avondale Shipyards,**

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[3]The Benefits Review Board has recently made clear, however, that *Greenwich Collieries* does not affect the section 20(a) presumption in any way. *Holmes v. Universal Maritime Services Corp.*, 29 BRBS 18, 21 (1995) (the decision "did not discuss or affect the law regarding the invocation or rebuttal of the Section 20(a) presumption").

Inc., 19 BRBS 15 (1986); **Rajotte v. General Dynamics Corp.**, 18 BRBS 85 (1986). Also, when claimant sustains an injury at work which is followed by the occurrence of a subsequent injury or aggravation outside work, employer is liable for the entire disability if that subsequent injury is the natural and unavoidable consequence or result of the initial work injury. **Bludworth Shipyard, Inc. v. Lira**, 700 F.2d 1046 (5th Cir. 1983); **Mijangos**, **supra**; **Hicks v. Pacific Marine & Supply Co.**, 14 BRBS 549 (1981). The term injury includes the aggravation of a pre-existing non-work-related condition or the combination of work- and non-work-related conditions. **Lopez v. Southern Stevedores**, 23 BRBS 295 (1990); **Care v. WMATA**, 21 BRBS 248 (1988).

In the present case, Claimant maintains that he suffers from chronic pain and other physical and mental effects that render him unemployable as a result of his 1995 closed head injury. Chronic pain syndrome is a recognized disorder when there is no other continuing objective evidence of injury. **Anderson v. Todd Shipyards Corp.**, 22 BRBS 20 (1989). In that case, the Administrative Law Judge relied upon the records of one physician who treated the Claimant after a back injury and the testimony of the Claimant to make the determination of total disability and to award benefits. Likewise, in this case, I give the most weight to the testimony of Dr. Birky, the neurologist, and Claimant's treating physician, who gave the uncontested diagnosis of his original closed head injury and has followed Mr. Riley since the time of his injury.

It is my opinion that when evaluating a chronic pain case that has its roots in a palpable, diagnosed injury, the credentials and the reports of the treating physicians are crucial to the determination. The duration and frequency treatment by the treating physician must be considered as well as the reasoning and depth of the reports. This does not mean that credentials and reports of evaluating physicians are not important. They are, both in law and in reality. However, to separate the legitimate claims based upon chronic pain from those that are not, the long term treating physician's opinion must be given great weight when the credentials, treatment and reports are considered.

Here, Dr. Birky, a neurologist treated Mr. Riley from the outset, with help from Dr. Winikates, whose reports do not differ to any significant degree, from those of Dr. Birky. The history of their treatment and monitoring of Mr. Riley is both long term and consistent, with his medication regimen and referrals for specific tests consistent with the effects of chronic pain.

In addition, he receives the backing of Dr. Hines and Dr. Winikates on the physical aspects of the injury, and of Dr. Davis on the psychiatric aspects. As noted elsewhere, even Dr. Bilkey finally defers to Dr. Birky's opinion on Mr. Riley's exertional capabilities. I find that when the limitations of Dr. Davis are combined with the restrictions that Dr. Birky describes, Mr. Riley could not sustain even sedentary employment.

The Employer presented evidence that the musculoskeletal injuries had been resolved, and that there were no other contributing factors from prior evidence of clonical seizures or from post traumatic stress syndrome, thought to be related to his Viet Nam experiences, thus severing his present condition from the 1995 injury. It is true that the presumption may be rebutted by such negative evidence, if it is specific and comprehensive enough to sever the potential connection between the particular injury and the job-related accident. **Swinton v. J. Frank Kelly. Inc.**, 554 F.2d 1075, 1083 (D.C. Cir.), *cert. denied*,

429 U.S. 820 (1976). Although in *Swinton* the evidence adduced was insufficient to meet the requirements of this test, the Board has held that a combination of medical testimony, a credibility determination, and negative evidence constituted sufficient evidence to rebut the presumption of causation. **Craig v. Maher Terminal**, 11 BRBS 400 (1979). Thus, the determination of whether the section 20(a) presumption has been rebutted is dependent on the particular facts of a given case rather than whether the evidence meets a set of particular requirements: it is, in other words, it is an *ad hoc* inquiry.

Here, Dr. Birky, diagnosed the original closed head injuries and effects related thereto including vertigo, balance problems when walking, memory loss, and other effects on his daily activities of living. As time went on, even he thought that the effects should have resolved. Gradually, however, he concluded that the effects of the developing chronic pain were real, and limiting Mr. Riley's daily activities. He had Mr. Riley on a daily regimen of strong medications that produced specific results, which he has maintained. Although there is some question of what would happen if he could be weaned off from those drugs, no physician here was able to specifically contradict, the continued necessity for them at his level of activity, except for the Relafen and Daypro, one of which may be substituted for the other. This would not, however, necessarily reduce the total dosage of those medications.

While evidence demonstrated that he had specific residual capacity to perform certain exertional activities that would permit him to work at light or sedentary jobs such as being able to lift or carry 35-40 pounds for certain limited periods of time, the effects of the short term memory loss, loss of balance, and indeed, the effects of the medications themselves were sufficient to prevent Mr. Riley from sustaining such work, according to Dr. Birky, backed by Dr. Hines and Dr. Estes. For one thing, the number of breaks alone, 10-15 minutes each hour, would be enough to render him unemployable.

Dr. Birky testified in his deposition that the August 10, 1995 injury is responsible for his present neck pain symptoms since they started after the accident. His final diagnosis was "post-traumatic neck pain," persistent headaches and persistent dizziness, which, together, he called "post concussion syndrome," the cervical strain to his neck being from trauma and not something such as bending his neck. He stated that degenerative changes in his neck would not have been caused by the accident, but any underlying condition of the neck may predispose one to have more symptoms from a set accident thus if the underlying neck structures were normal. Based upon the uncontradicted evidence that the kind of neck pain symptoms that Mr. Riley had after the accident did not exist before it, I give the most weight to the opinion of Dr. Birky, who is a neurologist and Mr. Riley's treating physician. Likewise, I give most weight to his conclusion that Mr. Riley continues to suffer headaches, lightheadedness, dizziness and memory changes, concentration difficulties and changes in personality at times to his "post-concussion syndrome" due to his 1995 injury. Dr. Birky's response to questions on cross examination do not alter my evaluation of his opinion. Again, he states that each medication still seems to be necessary. The report of Dr. Estes is consistent with his findings.

With regard to the negative EMG attached to Dr. Winikates' deposition noted by the Employer, he states that the abnormal brain wave patterns may only be present intermittently so that such negative studies do not rule seizures out. In other words the tests must catch them when they happen. I credit the combination of Mr. and Mrs. Riley's consistent testimony on this point, as related to the history given at the time to Dr. Birky, and his coupling of that with the opinion of Dr. Davis.

Even Dr. Bilkey, while finding that there were no musculoskeletal conditions that could be identified for treatment, and that there was no specific evidence of continuing clonical seizures or traumatic stress syndrome, specifically deferred to Dr. Birky, and did not contest his diagnosis of chronic pain, or his treatment of it. In fact, he refers Mr. Riley back to Dr. Birky to modify his restrictions as the final arbirter in the matter.

Dr. Simon's report acknowledges limitations but concludes that while Mr. Riley presents "no signs or symptoms of pyschiatric dysfunction," he finds that "he does appear to have significant impairment with respect to verbal recall and the ability to retain newly learned information (i.e. Delayed Recall). Psychomotor speed, learning ability and visual attention were also found to be impaired according to the TrailMaking Test. Finally, depressive sequelae appear to also be a compromising factor as Mr. Riley reports experiencing vegetative symptoms of depression, concern over physical problems, irritability and anergia." His primary diagnostic impressions at Axis one is: "Organic Personality Disorder - Depressive Disorder, NOS."

Dr. Conte's attempt to demonstrate vocationally that Mr. Riley could perform certain light and sedentary jobs in the Cincinnati and Lexington job markets within those exertional restrictions was itself flawed by the failure to show specific jobs with specific employers that could be sustained by Mr. Riley.

In this case, in an attempt present "specific and comprehensive" evidence to sever the connection between Claimant's harm and his employment, the Employer relies upon certain findings of Dr. Birky and Dr. Bilkey, a report of Dr. Hines who examined Mr. Riley at the request of the Employer, statements in the reports of Dr. Estes who treated Mr. Riley for heart problems, Dr. Simon, a clinical psychologist, Dr. Conte, a vocational counselor who submitted two reports at the request of the Employer and Dr. Davis, a second clinical psychologist who concluded an examination and submitted a report on behalf of the Claimant.

In summary, the Employer basically questions whether Claimant's "multiple symptom complex which purportedly impairs his ability to work can be attributed to that one event." (ER Brief, p. 15) With that, it briefly skims the reports of Dr. Estes regarding symptoms from Mr. Riley's heart condition which requires some medications; eye problems requiring medications; an arthritic condition that could contribute to his balance and walking problems; a listing of some of Mr. Riley's problems that could also cause dizziness and light headedness, such as the staring spell that might have resulted from some of these problems, and his "many medications," when Dr. Birky and Dr. Winikates clearly testified that the symptoms in question that followed his closed head injury were responsible for his present disabling conditions. I also find that Mr. Riley's attempts to drive his car, maintaining his driver's license, and driving to one appointment do not change this result. This does not constitute evidence that he should be driving, or that he could do so on a sustained basis to hold a job.

The others may have some operative effect but the key matter for this case is that those flowing from Mr. Riley's closed head injury are sufficient to keep him from working. Despite all the speculation, none of the physicians contradicted the opinion of Dr. Birky that those symptoms were causing his present physical condition with its exertional limitations, or that of Dr. Simons or Dr. Davis which took the psychiatric limitations following from his injury, which Dr. Birky finds does limit his ability to work when the question of sustaining such work is considered. In combination, I find that the Employer has not presented sufficient evidence to sever the connection between Claimant's 1995 injury and his present limitations that prevent him from sustaining even sedentary employment.

It is my conclusion that Dr. Birky's analysis as the treating physician over the course of Mr. Riley's treatment and recovery, in combination with that of Dr. Winikates, Dr. Simons, and Dr. Davis establish that he is totally and permanently disabled; that he reached his date of maximum medical improvement on June 6, 1996; and that he plateaued there with a chronic pain disorder as a direct result of his 1995 injury. It is to be given greater weight than the opinion of Dr. Bilkey in his analysis of Mr. Riley's medical condition; and the vocational reports of Dr. Conte.

Medical Benefits:

Under the provisions of 33 U.S.C. § 907(a), the Act obligates the payment of medical expenses for such period as the nature of the injury or the process of recovery may require. See, *e.g.*, **Perez v. Sea-Land Services, Inc.**, 8 BRBS 130 (1978). Claimant is entitled to the reimbursement of medical benefits reasonably and necessarily incurred as a result of his work related injury in this case. The Employer has agreed to pay these benefits upon submission of the appropriate documentation.

Attorneys Fee:

No award of attorney's fees for services to Claimant is made herein, since no application has been received from counsel. A period of 30 days is hereby allowed for Claimant's counsel to submit an application, with a service sheet showing that service has been made upon all parties, including Claimant. The Parties have 20 days following receipt of any such application within which to file their objections. The Act prohibits the charging of any fee in the absence of such approval.

ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I issue the following compensation order. The specific dollar computations of the compensation award shall be administratively performed by the District Director. Therefore,

It is therefore ORDERED that:

1. Commencing on June 6, 1996, Claimant's date of maximum medical improvement, the Employer shall pay to the Claimant compensation benefits for his permanent total disability.

2. Claimant will be paid benefits based upon the difference between his average weekly wage at the time of the injury, $758.35, and his total loss of wage-earning capacity after the injury, which has resulted in a loss of earning capacity of $758.35, and a compensation rate under Section 8(a) of the Act of two thirds that amount, or $505.59 per week, plus the applicable annual adjustments provided in Section 10 of the Act, and subject to corrections that may be required in the precise calculation of these figures by the District Director.

3. The Employer shall also receive a credit, of all payments of compensation made to Claimant herein from August 11, 1995 to present, if any, including $146,621.10 through April 13, 2001, and those continued thereafter.

4. The Employer shall reimburse such reasonable, appropriate and necessary medical care and treatment expenses as the Claimant's work-related injury referenced herein may require, subject to the provisions of Section 7 of the Act.

5. A period of thirty (30) days is hereby allowed for Claimant's Counsel to submit a fee petition. The Employer's attorney shall file, within twenty (20) days of the receipt of this fee petition, any objections it may have to this fee petition.

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THOMAS F. PHALEN, JR.
Administrative Law Judge